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SUBVERBAL COMMUNICATION AND THERAPIST EXPRESSIVITY TRENDS IN CLIENT-CENTERED THERAPY WITH SCHIZOPHRENICS [*]

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Introduction

Growing out of client-centered therapy and especially its recent application [**] with hospitalized schizophrenics there is now emerging a mode of psychotherapy which centers on the "experiencing" of the two persons in the therapy interaction, rather than on the discussed verbal contents.

This development is similar to recent trends in other orientations [1, 2, 3, 16, 18, 24, 25, 26, 29, 31, 32]. Today there is a strong tendency to emphasize the interaction in psychotherapy, to emphasize that two human beings are involved, and to focus on the concrete subjective events occurring in these two persons, rather than only on the verbal contents being discussed.

Basic to this development is the view that psychotherapy involves "experiencing" (by whatever name), a somatic, inwardly felt process the manner and meanings of which are affected by the interaction. Some attention is being given [4, 23] to the theoretical problem of how inwardly felt bodily events can have "meaning," be "explored" and "symbolized," and how these concrete implicit "meanings" can be affected and changed by interaction. Now that psychotherapy is widely thought to involve a concrete feeling process, we are less specific about the (still vital) role of cognitive symbols and exploration. The different orientations use different cognitive vocabularies, yet their patients and clients appear able to work with any of these vocabularies. Apparently, any good vocabulary can be employed as a symbolic tool for "working through" and interacting. It appears that personality difficulties lie in the "pre-conceptual" meanings of experiencing—that they are concrete, and that they are amenable to symbolization and change through interaction using any of the many different therapeutic vocabularies we have.

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Apparently it is not so much a question of just which vocabulary you use, but rather, *how* you use it. If used in "direct reference" to experiencing, then more or less any vocabulary can be well

employed. If used as abstract explanatory substitutes for the individual's experiencing, no cognitive vocabulary will engender much constructive personality change. Of course, this is an opinion which awaits much more research support than we have so far [7, 10, 15, 17, 27, 28, 30], but it is a widespread current trend in therapeutic thinking,

Not only the best use of words, but also the best use of therapist behaviors, would seem to depend not so much upon just what the therapist behavior is, as on *how* the behavior relates to and affects the individuals' experiencing. Let us say the therapist has just said: "I guess much of what you feel is too hard to say." A given therapist behavior has a certain relationship to the therapist's own ongoing experiencing (in this example, it is expressive of his implicit caring for, and interest in his client, as well as of his disappointment at not hearing much from him), and the behavior also has a certain relationship to the client's ongoing experiencing (let us say it implies something about the client's fear and inability to express himself and that he has unclear but painful present feelings).

The attempt to specify just what therapists should and should not do tends today to concern not so much *what* behavior is used, but more just *how* it is used. Furthermore, this "how" concerns how the behavior relates to the experiencing of the two persons.

For example, years ago there was a client-centered "technique." It involved such rules as: The therapist should not ask questions. The therapist should not express his own feelings. The therapist should not inject anything that does not first come from the client. The therapist should rephrase (more deeply if possible) the client's present, partly unexpressed feeling.

The principles underlying these rules have not changed. However, today we might say: If the therapist asks a question, it should point at the client's experiencing, or, the therapist should state his own implicit reasons for needing to ask the question, thus making the interaction more open and probably more warmly personal (since the therapist probably asks the question in the service of some interest or concern *for* the client).

Today, we would probably say: The therapist must express his feelings often when he works with a highly nonexpressive, externalized, and unmotivated client. If the client has no notion or intention to make the interaction intimate, meaningful, purposive, and close, [Page 107] then the therapist must make it so by expressing some of his own thoughts and feelings concerning his relationship with the client. He may do so without imposing his views upon the client's experience. He may express maximal interest and wish to hear the client's experience [9, 10, 14].

The above paragraphs are intended to explain how the basic principles may be the same, yet they may be applied not to kinds of therapist behavior, but to *how* any mode of response arises from the therapist's experiencing, and how it relates to the client's experiencing.

Purpose of this paper

The purpose of this paper is to offer a few specifications of just *how* subverbal communication and therapist expressivity can work. Such specifications are needed because, if therapists take it as a rule to "express" anything whatever, in any way whatever, obviously we are then left with no guidelines at all. The specifications will, however, concern not *what* but *how* such therapist self-expression can be part of a therapeutic method. Similarly, "subverbal' communication always

sounds mysterious—how is anyone to know what the client means when he can't say what it is? Again, the specifications I would like to offer concern not "what" the client means (and not how we can guess "what" he means). The specifications concern how client's and therapist's words can be employed to point at and refer to experiencing

The specifications offered here do not necessarily involve agreement as to what is most effective in therapy. Rather, we cannot even discuss what is most effective, unless we build a vocabulary of distinctions and specifications. Then we can discuss whether this or that specific mode is effective or not. My contention in this paper is that such a vocabulary should not remain moribund by the distinctions between the different "schools" ("reflections of feeling," "interpretation," etc.) but should be based on distinctions concerning the role of "experiencing." Such a vocabulary would be *applicable* in all the schools of therapy, though not everyone need then agree on just which distinct modes of response are desirable.

Schizophrenics and neurotics—some research findings

Although psychotherapy seems to me to be *the same* process in neurotics and in schizophrenics, the differences manifested by schizophrenics are important, because here we find written large and unavoidable some of the factors which we may overlook in usual psychotherapy. I would like, therefore, to cite some of our research findings [Page 108] on psychotherapy with schizophrenics. For example, we often tend to overlook the problems of externalization and trivial talking in ordinary therapy. We know it happens and that such clients are most often eventually failures, but how different would be our reaction to this problem, if nearly *every* person we saw in therapy confronted us with it. We would then *have to* do something to meet the problem.

We do not as yet have conclusive outcome findings about the effectiveness of psychotherapy with schizophrenics. Therefore, what I have to say will not be evaluative. Rather, I will be describing what we are actually doing in our therapy sessions and how we have come to proceed as we now do.

The sample of hospitalized individuals diagnosed "schizophrenic" with whom we have been working was selected on the basis of age, socio-educational class, sex, and length of hospitalization. By these means we avoided the usual method of selection by which psychotherapy is most often given to motivated individuals or to those who reach out and respond to staff, or to those who are most overtly and dramatically ill and attract attention as challenging cases. Instead, our sample was selected to be representative. I think that most of the hospitalized population called "schizophrenic" consists of individuals like these, unmotivated and inexpressive. The problems of employing psychotherapy with such individuals are being widely discussed and what I will describe is intended as part of this current discussion.

Here are some research findings to express the initial characteristics of these individuals, and how therapy with them progressed:

The Kirtner in-therapy behavior scale [17] had been used in earlier studies with neurotics. The scale predicted success or failure in therapy from ratings of the first interview. Failure was predicted if in the neurotic individual's first therapy interview he showed extremely little expression of affective difficulties and little awareness of how his own personality contributed to his difficulties. We

applied this scale to the first interviews in our sample and found that fifteen out of eighteen first interviews predicted failure. In other words, in addition to being unmotivated and not very expressive, these persons usually began therapy by talking about anything but themselves and this means a poor prognosis judging by previous research.

Both talking and silence are used by these individuals in a nonexpressive way. Either there is a non-stop torrent of trivial talk, or there is a great deal of silence, so that both talking and silence present the therapist with the problem of initiating meaningful communication. We compared the speech and silence patterns of the schizophrenics in the second interview with second interviews of neurotics. [Page 109] By comparison, we found that at the .002 level of significance [11], the schizophrenics either speak much more than neurotics or else they are much more silent. Half the schizophrenics show either less than one per cent silence in the interview or more than forty per cent.

This initial therapy behavior changes later. At the 30th interview the Kirtner ratings predict failure for only three of thirteen. Their behavior thus has changed greatly toward expressing affective difficulties and viewing their personalities as involved in their difficulties. This change in behavior rated on the Kirtner Scale correlates significantly with change on the Experiencing Scale [12]. These individuals thus give indications of movement along the continuum of the process of therapy [5, 6, 20, 21].

The MMPI also reflects this change [13]. Initially, failure predicted individuals—those who express little explicit affective difficulty in interviews—also show lower clinical MMPI pathology and higher defensiveness (K and L). Ranging these subjects according to the most failure predicted initial Kirtner ratings, after six months their MMPI profiles have changed completely. For all but one in the most failure predicted half, even the two top scales are now different scales. Also their D scale scores have risen sharply. This change indicates not so much a drastic change in basic personality, as it indicates that these individuals become able to express their genuine selves and become able to express their bad feelings.

Thus to a large extent, we did succeed in initiating more open expressiveness and engagement in the process of therapy by these individuals, as measured by MMPI and by in-therapy behavior and process scales. The Kirtner Scale arose from the realization that failure-predicted individuals do not engage in genuine therapy behavior—neither initially *nor* later on. But among neurotics such individuals made up only a small percentage. Since schizophrenics so largely exhibit this type of initial therapy behavior, it was imperative that modes be developed [8] by which genuine therapy could be engendered with unmotivated, externalized or silent individuals,

Therapist expressivity

In the research with schizophrenics our major hypothesis is that certain attitudinal *conditions* expressed by the therapist are expected to determine the amount of change and the quality of the therapeutic *process* in the client. Rogers [19, 22] posited three conditions necessary and sufficient for psychotherapy. They are: "empathy," "unconditional regard," and "congruence" or "genuineness." This last, "congruence," implies that the therapist attempts to drop any personal or [Page 110] professional artificiality, any maneuvers or postures, and that he "be himself." In our

work with schizophrenics this condition has become more and more important. We have become very free of formulae—even that most characteristic of client-centered modes of resounding, which was called "reflection of feeling." As the term "empathy" implies, we strive as always to understand the sense the client's feeling from his own inward frame of reference, but we now have a wider scope of different behaviors with which therapists respond to clients. Genuineness or "congruence" involves a spontaneous variety of behavior. I believe that it was in part the undesirable tendency toward formulae and stereotyped ways of responding which led Rogers to formulate this condition of "congruence" as essential.

To "be himself" genuinely has meant that the therapists have become more expressive. The therapist much more often expresses his own feelings, his experiencing of the moment. When the client expresses himself, then naturally the therapist's present experiencing consists largely of an empathic sense of the client's meaning. But, when the client offers no self-expression, the therapist's momentary experiencing is still not empty. At every moment there occur a great many feelings and events in the therapist. Most of these concern the client and the present moment. The therapist need not wait passively till the client expresses something intimate or therapeutically relevant. Instead, the therapist can draw on his own momentary experiencing and find there an ever present reservoir from which he can draw, and with which he can initiate, deepen, and carry on therapeutic interaction even with an unmotivated, silent, or externalized person.

Also, "congruence" for the therapist means that he need not always appear in a good light, always understanding, wise or strong. I find that, on occasion, I can be quite visibly stupid, have done the wrong thing, made a fool of myself. I can let these sides of me be visible when they have occurred in the interaction. The therapist's being himself and expressing himself openly frees us of many encumbrances, artificialities and makes it possible for the schizophrenic (or any client) to come in touch with another human being as directly as possible.

However, it would seem that many of the erstwhile guidelines for therapeutic *behavior* have disappeared. Only the *basic attitudes* are specified, not what one does to manifest or express them. Does this mean we do—just anything at all? Let me describe this *procedure of therapist expressiveness* further in three respects:

- (1)"*non-imposition*": In working with unusually defensive, withdrawn or fearful individuals we find it even more important, than ever, not to impose ourselves on them. How is non-imposition consistent [Page 111] with a therapist who expresses more of himself more openly and actively, and who initiates relationships by expressing himself? Tentatively, I think the answer is: The therapist can be more active and *at the same time* present less imposition and threat than ever, if he will express *himself*—his own imaginings, his own feelings, desires, the events which transpire in him, and if he does this clearly and explicitly as statements about himself, or about events transpiring within him at the moment. In this way he shares himself more openly, yet he does not impose his views onto the client's experience. He speaks for himself. He does not impose or force anything upon the client's experiential space, or confound events in himself with events in the client.
- (2) "*a few moments of therapist self-attention*": To respond truly from within me I must, of course, pay some attention to what is going on within me. As I am interacting with the client, a good deal of what transpires within me has to do with him—consists of my imaginings of

him, my observations of his reactions, my reactions to him, etc. But, within me these occur as mine, as me. They are not deductions about him. They are what is happening to me now, my lived moments with him. To formulate and express these I require a few steps of self-attention, a few moments in which I attend to what I feel. Then I usually find a great deal that I am willing to share. It would be wrong to say that I express *everything* that is going on in me, since a thousand things are going on in me in any moment and, these thousand cannot even be separately formulated, much less expressed. Also, I don't blurt out impulsively the first thing which happens to come to mind. I live a few moments inwardly and by this means I find in myself some response to the client, or to what has been happening between us, or in our silence. Even when little is being said, I find that I have desires, fears, disappointments, and wishes for more meaningful communication. I can voice these. With a few moments of self-attention I can find my genuine response to the moment. If, while the client talks, I feel bored, I do not blurt out "You bore me." I find, with a few seconds of attention to my own experiencing, that my boredom really consists of my missing something from him, something interesting and personal. I find that I strongly wish for this personal expression of his, which I miss. I find I have much welcoming for it ready, and that is going to waste. I find that I can imagine the kind of personal communication which I sense missing in his verbal stream. I can express these senses of lack, wish, and imagination, and I can express them as *mine*. Much of my own feeling process when I am with someone does usually consist of these rather specific momentary events, reactions, wishes, and senses relevant to the other person. For example, let us say I have just [Page 112] said something and gotten no response. I think that it may have been very much the wrong thing to say. I need not simply feel bad about having done the wrong thing. I can say I feel bad about it and why, as well as the fact that this happens to be what I am now feeling, but, that I am not at all sure about what *he* is now feeling.

The few seconds of self-attention nearly always bring two developments in the feeling I have: (1) it becomes more truly something of me, rather than about him; (2) it becomes much more possible to share it. Thus, even though it is my genuine momentary reaction *to the client* in the interactive moment, it is also *genuinely mine* and does not impose itself on what he experiences. I can say, when it is true, that I am not at all sure what he feels at the moment.

- Thus, the two specifications I have stated require each other: 'non-imposition" requires "a few moments of self-attention" so that I may find what I truly feel and state it non-imposingly, as mine.
- (3) "*unmuddied responsivity*" : I want now to add a third specification of therapist expressiveness. When the client gives me nothing intimate, or self-expressive—*it is then* that I must draw on my own momentary reservoir to find within me my response to him—an intimate expression of me in this moment with him. However, when the client is in the process of expressing himself to me, then I find within me chiefly my sense of *his* expressions and I try to tell him with unmuddied simplicity what I understand *him* to feel and think. It is just as important that I sense and state his experience as *his* (as purely as possible from his own frame of reference), as it is to make clear that my experiential self-expressions are mine, when that is the case.

> Very often, when the client is in the course of expressing himself, a response which simply states what the therapist understands the client to think or feel is a powerfully effective response. Often it is the only possible helpful response.

I have described three specifications of therapist expressivity: "non-imposition," that he states his self-expressions as his own; "a few moments of therapist self-attention" enabling him to find his true response of the moment; "unmuddied responsivity" in stating the client's feeling or thought when the client is expressing himself and the therapist finds within himself chiefly his sense of the client's message.

With schizophrenics and with many others, it is the therapist who—if anyone does—will initiate the relationship, will begin open expressive interaction, and will first express warmth, care, interest, and a person to person quality. If the therapist must sit passively, or argue intrusively, I don't think he is likely to form a relationship with an individual who does not already wish for therapy or for a relationship. [Page 113] The therapist's moment to moment expressiveness largely determines the quality of the interaction, at least at first, and especially with unmotivated individuals. The therapist's self-expression can make the interaction eventful, personal, and expressive even if the client is consistently silent or expresses only trivia. The therapist's expressions—the events occurring in himself—will concern the interaction and will deepen it, when they are spoken. *Both* persons tend to experience an eventful open and personal *interaction* process even while only one of them is verbalizing his felt side of the interaction.

This brings me to the second main observation I want to discuss:

Subverbal interaction

Perhaps subverbal interaction is so important with schizophrenics because so much of their experience seems incommunicable to them., seems cut off from other people in its very nature. Often, the content—the *what* is *said*—is only a small bit, perhaps a bizarre bit—which issues from an inner turmoil whose incommunicable significance is enormously greater and different than any bit of verbal content. The incommunicable nature of *what* the individual experiences, and the fact that he is cut off from other people—require that one responds not to some bits of verbal content, but to the experiencing. In this way one attempts to restore the connection, the interpersonal *interaction* process within which the normally functioning individual lives and feels.

(1) Response to words in reference to experiencing: This is not to say that one mysteriously responds to "experiencing" without *having some verbalization to go on*. Rather, one views verbalization differently. Instead of concerning oneself with verbal content one asks: What larger inward process is this bit of verbalization coming from? One's answer to this question will be something felt, a conceptually vague but concrete felt meaning of the client's, which the therapist can only imagine. But the therapist need not know it, guess it, or correctly imagine it. He can point his response at it, no matter how unknown it is to him.

For example, my client says that he wants to know where, in the hospital, they keep that electronic machine which compels people to return to the hospital. He can prove there is such a machine, he

says, because how else can you explain the fact that patients with ground privileges return to the hospital of their own accord?

Now I could, of course, argue with him that no such machine exists, that I would know it if it did, that he does not trust me to tell him the truth on that subject, that he is having an unrealistic hallu-[Page 114]cination or, closer to his emotions, that he does not like the hospital and cannot understand anyone's coming to it voluntarily. But what is his *experiencing* as he talks of this machine? What is the "pre-conceptual" or felt process from which this bit of bizarre verbalization comes? I don't know, of course. But I want to respond to it somehow. So, I say back to him: "You feel it controlling you?" "Of course, I sure do," he says and goes on to say that the machine makes him feel "not himself." This phrase I recognize as somehow communicating to me something of the inward experiencing at which I pointed my words.

I am using this example to illustrate what I mean by pointing one's words at the experiencing, the wider inward process about which one does not know very much—except that it is there—and that verbalizations arise from (or in regard to) it. Actually, I had not quite correctly imagined what he experienced. For my part, I thought he felt inwardly compelled by the machine but his next words expressed a different, unexpected, but still understandable aspect of his experiencing. And this is what usually happens. Usually, when one points one's words at the experiencing rather than the verbal content, one finds that one's imagination was not accurate, but the very fact of responding to this experiencing which is always there establishes the possibility of communicating concerning the deeper meanings from which verbalizations arise.

This man went on to tell me that his "not feeling like himself" was the result of the fact that his parents moved into the country when he was a schoolboy, and that therefore he had to ride a bus to school through the snow many miles. Again, one might have argued that this alone could not have caused him to feel "not himself." But one senses that this bit of memory comes from a whole pageant of memories, from the time when he began "not being himself." I imagine endless, weird, snowy bus rides, I sense his feeling cut off from everyone he knew, way out there, snowbound, in the country, those many years all of which he now feels, I suppose. I say something about these bus rides and feeling cut off and we establish a new vehicle of communication. He, too, now uses the phrase "feeling cut off." Perhaps I was right—but more importantly, I spoke to that mass of felt meanings and thoughts, that feeling process, which was just then occurring in him as he spoke, not to what he spoke as a bit of verbal communication. And, in this way, although often very stumblingly, one can gradually communicate more meaningfully, despite bizarre or externalized and trivial verbalization.

(2) Response to silence in reference to experiencing: But, I have chosen easy examples. Before this man told me about the electronic [Page 115] compelling machine we spent six hours together with only trivia and silences. *It was necessary for me to respond to him when, as yet, he would share nearly nothing with me*. What was I trying to do with him, he wanted to know, and when would I be through, when would he not have to come anymore? When could he go home? He had nothing to say. Silence, more silence. Once I interrupted one of these silences in which he had been sitting very quietly apparently thinking, and said: "(very gently) You seem to be thinking some important thoughts or feelings. I don't know, of course, but that's what I imagine. I don't want to interrupt, but I sure would like it if you felt like sharing those thoughts with me." He said, very loudly: "What?

Who me? What, thinking what?" It was quite clear that he was startled. Also, he seemed to consider my statement inappropriate, false, and stupid. Yet, it is necessary to bear such moments for how else can our interaction come to be warm and close and personal, if it is not so now, and one of us doesn't make it so?

After a while such expressions of mine, such imaginings, or implications that we both do have important feelings are no longer met by surprised rejection but often by a silence that is close to assent, and then, later, by an explicit sense on the part of the client that our silent times are subverbally important, deep, and eventful. One client named it when she said: "I'm having quiet therapy for a while."

An even better description of the inward feeling process which can occur in this subverbal interaction came later, when she could describe it much more specifically. She says: "When I get upset, I can't breathe. I know I breathe, of course, but it feels like I can't. Here, after I've been here a little while, I breathe."

She means, I think, that in these silences there is an inward flow, an *inward feeling process* which comes alive or released.

I do not mean to say that subverbal interaction occurs only during silence, although silence appears to be important for it. In my first examples which came from a conversation, I tried to show that, while we observe silence and words (and the words before and after a silence) very much more is occurring within the person in his feeling process. Often, what he says and how he looks, gives us a little to go on in responding to this feeling process. But, even when there is nothing to go on, one can still respond to this process, point one's words at it, express something from one's own felt process, thereby engendering a deeply important subverbal interaction.

(3) Response to incomplete verbalizations in reference to experiencing: Subverbal interaction in one extreme might be illustrated by the man with whom I spent nearly six months of bi-weekly meetings [Page 116] which consisted of my standing next to him on the ward. Whenever I asked him to come into an office with me he became verbal, but only to tell me to go away and leave him alone. Yet, when I would come only to stand next to him where he stood on the ward, he would remain, usually, for the whole hour despite the fact that he knew I would leave if he walked away. During such an hour we would exchange many glances, motions, and a few sentences. Often—that is to say every few silent minutes, I might say something of the tension I felt, and of my wish that our silences would feel all right, as well as of my wish to hear from him, and my knowledge of his discomfort and tension with me. After a while he would each time say a sentence or two, often in the nature of summaries that seemed to stem from much ongoing inner turmoil, feeling and thinking, such as: "Maybe I *am* crazy," or "Someone must have a use for a person," or "I don't know if you're for me or against me," or "They *just* don't have a heart," or "I'd like to take them by the shoulders and shake them to wake them up." Some hours might pass without such expressions. Sometimes he would accept my responses to these statements, at other times (more often) he would show me that I could more easily be talked to if I was quiet: If I responded verbally he would say "don't pressure me," or "you're too curious," or "maybe you *are* against me," or "it's awful hot today." At slight movements, or unsureness or verbiage from me he would react with sudden black looks or leap away three feet. So I learned to be *quiet while* he talked, perhaps a few minutes *later* I

might tell him something of what I thought about it. A few minutes later these would then be *my* thoughts about it.

When I stood next to this man in silence, it is not the case that nothing happened, when we were silent. Clearly, he was very active inside himself, and, to me it was also clear that I had a great deal to do with the process, and with the quality of this process, within him. It is this kind of interaction which I term "subverbal."

The development from early to later interviews involves the establishment of subverbal interaction. In quantity the proportions of speech and silence do not change from second to thirtieth interviews [11]. However, not only do the silences come to be subverbally important and therapeutic, but the verbalizations too b ecome more significant as the findings on the Kirtner and Experiencing Scales show. Subverbal interaction is thus not a giving up of verbal therapy, but rather a reaching for the deeper and wider feeling process of "experiencing" [4, 21] which occurs in every individual at every moment, and within which psychotherapy occurs. Words, no matter how relevant or irrelevant, are only messages from there, symbolizations of experiencing.

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I don't know whether the individual gets well within this largely subverbal interaction, or whether that happens only later with more verbal working through his difficulties.

Our observations do seem to indicate that at least in the initial phase, and, often in the later phase also, psychotherapy consists largely of *subverbal interaction* based on the *feeling process* ("experiencing") which is occurring within the individual. *Therapist self-expression* in the interactive moment can *engender* this subverbal interaction and therapeutically affect the manner of this feeling process.

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